



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Frank Leonard, II, M.D.

Respondent Name

Safety National Casualty Corporation

MFDR Tracking Number

M4-16-0642-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We seek full reimbursement for the outstanding balance of **\$315.00** ..."

Amount in Dispute: \$315.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 17, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2015	Designated Doctor Examination	\$315.00	\$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.
- 298 – The recommended allowance is based on the value for the professional component of the service performed.
- 89 – Professional fees removed from charges.
- 289 – The recommended allowance is based on the value for the technical component of the service performed.
- 4151 – An allowance was not paid for the Work Status Report. Reimbursement to RME doctors and designated doctors for the report is included in the reimbursement for the examination.
- OA – The amount adjusted is due to bundling or unbundling of services.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.
- PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary.

Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3), “The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.” The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is \$350.00.

Per 28 Texas Administrative Code §134.204 (j)(4), “**The following applies for billing and reimbursement of an IR evaluation.** (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area” [emphasis added]. The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion for the right upper extremity to find the Impairment Rating.

Further, 28 Texas Administrative Code §134.204 (j)(4)(C) states,

- (iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier ‘26.’ Reimbursement shall be 80 percent of the total MAR.
- (v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier ‘TC.’ In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR.

Review of the submitted documentation finds that range of motion, sensory, and/or strength testing was performed by a health care provider other than the examining doctor. Therefore, the correct MAR for the examining doctor for this examination is \$240.00. The correct MAR for the health care provider performing the range of motion, sensory, and/or strength testing is \$60.00.

Per 28 Texas Administrative Code §134.204 (k),

The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier ‘RE.’ In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with

subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

The submitted documentation indicates that the Designated Doctor performed an examination to determine the ability of the injured employee to return to work. Therefore, the correct MAR for this examination is \$500.00.

Per 28 Texas Administrative Code §134.204 (l), "The following shall apply to Work Status Reports. When billing for a Work Status Report **that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section** [emphasis added], refer to §129.5 of this title (relating to Work Status Reports)". Therefore, the filing of the DWC-073 is not payable when provided in conjunction with a Designated Doctor Examination performed according to 28 Texas Administrative Code §134.204 (i).

2. The total MAR for the disputed services is \$1150.00. The insurance carrier paid \$850.00. An additional reimbursement of \$300.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	Laurie Garnes	December 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.